City of Norfolk

REQUEST FOR REIMBURSEMENT

Instructions: Please complete all applicable spaces on this form for each reimbursement requested, attach appropriate documentation and forward to *"RA" Department of Human Resources, 100 City Hall Building, Norfolk, VA 23501*. Please print clearly. All reimbursement claims will be paid through the City's normal payroll system. Claims must be in the Department of Human Resources by close of business the first day of the Finance established two day payroll time entry period. Specific dates have been promulgated and can be verified by contacting your payroll clerk.

Name _____
(Last) (First) (Middle Initial)

Social Security Number _____ Business Phone _____

Department/Bureau _____

Home Address _____ Check here if new address ☐

_____

Reimbursement For:

Provider(s) of Service _____
(for self, spouse, children and eligible dependents)

SSN of Dependent Care Provider (if required) _____
(Dependent Care only)

All Person(s) Receiving Service _____

Relationship _____

Date(s) Service Provided ____/____/____ through ____/____/____

Total Amount of Reimbursement Requested $_____.___ Total dollar amount only

All attached receipts are:
(check only 1)

[ ] Child Care
[ ] Prescription Drug
[ ] Dental
[ ] Vision
[ ] All OTHER*

*Not combinations of child care, dental, vision, and RX

I certify that to the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been/will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

Employee's Signature _____ Date _____

Please check your receipts against the required documentation on the back of this form.

ALL medical RECEIPTS require the following:

- [√] fully itemized bill which includes:
- [√] date the actual service was provided (Not date payment was made)
- [√] name of the claimant (patient)
- [√] type of service (i.e. "office visit", dental procedures", surgery" etc.)
- [√] proof of payment (cancelled check or receipt from Dr.'s office)

You must be able to copy all of the above information directly from each receipt onto the front of this form.

Also:

- [√] All prescription drug claims must be accompanied by the prescription bag receipt or pharmacy print out.

- [√] Orthodontic payment booklet receipts that do not indicate the date of the service and the type of service (i.e. "orthodontic adjustments on DD/MM/YY") are not acceptable.

- [√] For inpatient/outpatient hospital procedures, you must include the fully itemized bill from the original date of service. Receipts that only indicate payment/co-payment information are not acceptable.

ALL child care RECEIPTS require the following:

- [√] fully itemized bill/receipt/contract for services which includes:
- [√] the dependents name
- [√] the period during which the service was rendered
- [√] the name, address, and taxpayer identification number of the individual or organization providing the service
- [√] a description of the service provided
- [√] proof of payment

You must be able to copy all of the above information directly from each receipt onto the front of this form.

Also: advanced reimbursement of future or projected expenses is not permitted. This means that you cannot requiest reimbursement prior to end of the dates of service…even if you pay for the service in advance. (services from November 1-15 cannot be reimbursed until November 15 services have been rendered, even if the care was paid for in October.